6 Years Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam OD	OS	OU	Allergies:	Temp:	Pulse:	Resp:	B/P

Audiometry		Corrected ☐ yes ☐ no	Wt:	%	BMI:	%	Ht:	%
☐ WNL	☐ Abnormal							

Speech: age appropriate ☐ yes ☐ no	Medications:

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ Language is expressive and understandable ☐ School attendance ☐ Reading at grade level ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sport/bike helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at Home ☐ Nutrition/exercise ☐ Street safety ☐ Discipline/redirect ☐ Reading ☐ School readiness ☐ Belt positioning booster seat <4'9''/air bags ☐ Provide opportunities for social interaction/invite friends over to play board games/dress up etc. ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Frustration/impulse control ☐ Communication/language ☐ Has friends ☐ Plays well with others/by self ☐ Is liked by other children ☐ Feels capable ☐ Expresses full range of emotions ☐ Pediatric Symptom Checklist ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Other ☐ Blood Lead Test **(perform at 36 – 72 months if not already done)**

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ IPV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**